



# California's Health

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## WHAT WE DON'T KNOW ABOUT ACCIDENTS\*

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California State Department of Public Health

In honor of the Ninth Annual Safety Congress, I would like to discuss nine points in regard to the accident problem. Most of these points are apparent already to many of you. Some of you may have been instrumental in bringing public attention to them in the first place. Others may be working on these problems now. My excuse for bringing them up here is to subject them to a somewhat different emphasis and viewpoint.

Here are the nine points:

1. Most people do not realize what a tremendous destroyer of life and health accidents are.
2. Too few people use even the most obvious personal safety devices.
3. We tolerate unsafe environment and unsafe behavior.
4. No one knows very much about the underlying causes of accidents.
5. We are particularly far behind in understanding the human factors in accidents.
6. We still cling to practices which long ago have been proved unsound or actually harmful.
7. We fail to recognize some important safety measures and experiences that should be obvious.
8. Most of us have no idea how much accidents cost each of us in actual cash each year.
9. We are much too timid about making and enforcing laws to require that safety be built into our environment in the first place.

1. *Most people do not realize what a tremendous destroyer of life and limb accidents are.*

Accidents are the most important cause of death in California and in the rest of the nation. It is true that cancer and heart disease kill more people, but victims of these diseases are older. Accidents kill the young—those who should have their whole lives ahead of them. Accidents are the leading cause of death to persons under age 35. They kill more infants and children from age 1 through 14 years than the four next most important causes of death combined. In the case of young adults ages 15 to 24, accidents account for three-fifths of all deaths, most of which are the result of vehicle accidents.<sup>1</sup> Cancer and polio, two highly publicized diseases, can't begin to compete with accidents as a cause of death to children and young people.

Information about non-fatal accidents and how many produce permanent handicaps is not readily available. Estimates of 100 disabling or crippling injuries for each accidental death have been made for the State of New York.<sup>2</sup> If we apply this formula to the accidental deaths in California in 1958 we get an estimate of almost 740,000 disabling or crippling injuries each year. In Alameda and Contra Costa Counties alone, almost 29,000 children were attended for injuries in 23 emergency hospitals in 1958.

<sup>1</sup> California Department of Public Health, Public Health Statistical Report, 1958. Part V, Vital Statistics, p. 40-42.

<sup>2</sup> Powers, J. H., Lincoln, J. F. "Accidents During Infancy and Childhood". New York State J. Med. 53:24, December 15, 1953, as stated in Two Reviews of Accident Research 1960, p. 12, Association for Aid to Crippled Children.

Anyone who is not alarmed about accidents just doesn't understand the situation. Any informed person should be alarmed.

2. *Too few people use even the most simple personal safety devices which have been scientifically proved to be effective in reducing death and injury.*

The best example of an effective personal safety device is the automobile safety belt. It has been four or more years since the value of seat belts was reported upon by Automotive Crash Injury Research of Cornell University, and additional studies have confirmed that there was a 35 to 65 percent reduction in injuries during accidents among persons using seat belts. Yet in 1958, only three percent of cars in accidents investigated by the California Highway Patrol had one or more safety belts, and far more than half of these were not in use at the time of the accident. Seat belts are the best bargain in injury protection available today, and any car owner who hasn't had them installed or isn't using them, is not acting in the best interests of himself or his family.

3. *Very few people know that accidents are predictable, preventable events which occur because we tolerate unsafe environment and unsafe behavior.*

In the 13th century, epidemics of bubonic plague were accepted as beyond human control and attributed to demons or the like. As long as these views were held it was considered that nothing could be done. Our attitude is not much better now in regard to accidents. Accidents are *not* inevitable.

\*Presented at the Ninth Annual Northern California Safety Congress, Oakland, California, April 11, 1961.

They can be controlled and in some instances, eliminated entirely.

Before we can reduce accidents effectively we need to know more about the various degrees of safe and unsafe behavior. We need to know what motivates people to behave in various ways. We need to know how this behavior interacts with various degrees of safety and unsafety in the environment. With this knowledge, perhaps we can engineer our environment to the point where only extreme forms of unsafe behavior can result in an accident and only very severe accidents produce injuries. This possibility should not be beyond the capabilities of a society which is orbiting various creatures in outer space.

Meanwhile some environments are so hazardous that even a mild degree of careless behavior eventually will fit into a chain of events leading to an accident. Let me illustrate. Near where I live, hundreds of youngsters walk to school on a heavily traveled roadway with no sidewalks. I've witnessed several "near misses" between youngsters and automobiles. The lack of sidewalks here presents an inviting setting for an accident. I think it can be predicted with alarming certainty that accidents will happen and will continue to happen near this school as long as this hazardous environment is tolerated.

What confuses us and lulls us all into accepting the status quo is that most of the time we are able to get by with an unsafe environment and careless behavior.

4. *No one knows very much about the real causes of accidents, whether they happen at home, on the highway, or at work.*

The fundamental need in the field of safety is for epidemiologic research into the causes of accidents. Safety should become a science in its own right. Whatever has been achieved in this field has come from the engineering sciences, but engineering is not enough. A safety program or safety research using experts only in the environmental phases of safety can never be entirely successful. After all, people are involved. It is time the engineering scientists were joined by the scientists who deal with people—psychologists, sociologists, bio-statisticians, and physicians—in conducting epidemiologic studies of accidents. All of these disciplines must find ways of working in concert, rather than "so-

loing" by themselves, in order to produce truly effective results.

By an epidemiologic study I mean one designed to bring to light all of the underlying facts which may contribute to certain types of accidents. Such a study should utilize the best scientific methods to discover, analyze, and evaluate all of the information leading up to and surrounding these accidents. Such an appraisal is necessary not only because we need to learn more about the true causes of accidents, but also because we need more information before we can do much about preventing accidents. Too many of our cherished beliefs about accidents turn out to be wrong!

For instance, if the driver of one car runs into another in broad daylight and no other cause is apparent we may assume "the sun was in his eyes." A truly thorough investigation might reveal, however, that mechanical failure of his car was a contributory cause. If this were repeatedly found to be so, then better designed automobiles, or improved regulations requiring proper vehicle maintenance, might break the chain of events leading to certain accidents.

It is interesting to note here that while thousands of dollars go into the investigation of every facet of an airplane accident, investigation into automobile accidents is quite superficial, and in California, at least, is done for the purpose of determining who is to blame, rather than what caused the accident.

Also we don't really know what is going on regarding the occurrence of non-fatal accidents. We do have fairly good information on the number of people who die in accidents, but that is where our information comes to a grinding halt. Fatal injuries are only a tiny part of the total accident spectrum we should know about. What few indicators we have show that the injury rates from accidents are going up. The lack of data is one of the greatest handicaps we face in assessing the problem.

5. *We are particularly far behind in understanding the human factors in accidents.*

Although it is much easier to understand "things" than it is to understand people, it is the role of people in accidents which stands in greatest need of knowledge, understanding, and appropriate action. One of the reasons this is so is that our scientific

knowledge concerning human behavior is much more difficult to obtain; it is much easier to gain knowledge of the "things" in our environment. Another reason is that the knowledge and techniques of people with special training in the behavioral sciences and in medicine have not been brought to bear on the programs and activities of the various governmental agencies with responsibility in accident prevention. An example of this fact is that there are no persons trained in behavioral sciences employed by the state agencies having major responsibilities for traffic safety in California. Also across the nation, there are only a handful of official agencies in traffic safety which have any behavioral science or medical personnel employed in accident prevention. The lack of representation of this important viewpoint tends to perpetuate itself.

6. *We continue to cling to practices and concepts which we think are important to safety but which have long ago been proved unsound or actually harmful.*

One example is the screaming, speeding ambulance which has killed more people than it has ever saved. Speed and urgency are more of an expression of anxiety or sense of drama on the part of persons who are not experienced in the care of the sick or injured and want to get the victims off their hands in the quickest, most dramatic manner. In most instances, speed in the transportation of the sick and the injured has nothing to do with the welfare of the victim; injuries can in fact be made worse by a fast, weaving ride. As far as speed is concerned, most victims would do as well by parcel post. In rare emergencies where time can make a difference, it is the first aid training of the person who takes charge right after the accident, not the speed of transportation, which is important. A conclusion reached in a study reported by the American College of Surgeons and the National Safety Council is that 25 percent of those permanently disabled in traffic accidents would not be crippled if proper care and transportation had been provided after the accident.

Another example of an unsound notion is that health and safety education is some kind of a "frill" like social dancing which doesn't belong in the public school curriculum.

Health and safety education is just as fundamental as the three "R's". I don't know about you, but I would rather have a son or daughter who turned out to be a safe driver than one who turned out to be a good speller. To what avail is a grade school, high school, and college education in our hazardous society if it does not have survival insurance built into it in the form of safety and health instruction every step of the way?

Another outmoded notion is that the majority of accidents occur to the same small group of people who are "accident prone." This concept has been proved false long ago. All of us are susceptible to accidents at times. We can't point our finger at a few people and say "you are the cause of it all."

*7. We do not recognize an important safety measure or safety experience when it should be obvious.*

Our freeways are the most effective single safety measure ever put into common use. The mileage death rate is cut to one-half and the injury rate (as nearly as it can now be measured) by two-thirds on California freeways compared to other roads. Other states report similar experiences. Our highway engineers have succeeded in producing a wholesale life-and-limb-saving arrangement for us, and I have never heard anyone advance a word of public appreciation or recognition. In fact, most people seem to be under the impression that the speed and monotony of freeways have increased accidents. If improving highways can bring about such a marked reduction in death and injury rates, think for a moment what is in the offing if similar degrees of improvement could be built into automobiles. Also, what about this often repeated statement that human frailties of the driver are at fault in 90 percent of the accidents? This can't be entirely true if improving the roadways alone accounts for more than 10 percent reduction in accidents.

Another obvious but seldom recognized fact is that we have great numbers of unsung "safety practitioners" in our midst, a group which will be named in a moment. These people are unaware of their talents, which have neither been studied nor exploited. The most striking and consistent picture in all phases of accident statistics is the remarkably

favorable safety experience of this group. Not until age 85 do they begin to show fatal accident rates equal or exceeding others in the population. They have less than one-third the expected number of accidental deaths. Since their experience has not been studied, we do not know how much of their avoidance of accidents is due to reduced risk, but it is reasonable to assume that it cannot all be assigned to less risk.

Who are these low risk people? At the risk of seeming immodest, I'll tell you. They are women and girls. This situation is fortunate; most homes have one or more. If women can chalk up this remarkable experience without knowing it, consider what they might do for the safety of themselves and their families if they tried! Tell a young housewife, for example, how she can reduce her chances of becoming a young widow or having her youngster topple out of the car during a trip on the freeway, and it will not take too long to get seat belts in her automobile; and Junior can be put to work to be sure everyone's belt is fastened before each journey begins.

*8. Most of us have little concept of the tremendous economic burden accidents place on us.*

Why are we in California spending about two and a half million each year in taxes to support children of parents who have died or have been disabled in accidents, but spending practically nothing toward research programs for reducing accidental death and injuries?

Why are we contributing millions through our taxes to provide support and medical care for crippled children but little toward preventing one of the major causes of crippling? Preventing only a small portion of accidents could lop a million or two off the bill each year.

Why is each of us willing to spend \$100.00 to \$150.00 a year for auto insurance when at \$10.00 per auto a sizable research and action program in traffic accident prevention could get under way which could show the way to cutting auto insurance perhaps by one-half to one-third?

Our way of living has changed more rapidly in the last 15 years than it has the preceding 50 years and the rate of change is expected to proceed at even a faster pace. We are already far behind in the search for new

knowledge and in the application of what we know about accident prevention. To catch up we must shake loose and spend money for research and for accident prevention programs. It will be paid back into our pockets a hundred fold. Accidents have been subject to less study than any other important cause of death.

Also, we must get rid of outmoded ways of doing things which prevent the application of what we *do* know about accident prevention. One example is the notion that safety requirements should not be retroactive. Just because fire hazards were built into hotels fifty years ago, does not mean they should stand that way until they burn down. They should be corrected the minute we know how. All safety requirements should be continually revised to represent the best available information and applied across the board. Any time a school is built, roads leading to it should have sidewalks before the school can open its doors. The fact that they were not required ten years ago when residences in the area were built should make no difference.

EDMUND G. BROWN, Governor  
MALCOLM H. MERRILL, M.D., M.P.H.  
State Director of Public Health

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9. *We are too timid about making and enforcing laws requiring that safety be built into our environment.*

We spend a tremendous amount of our government's time and money chasing down hazards *after* it is discovered that people are being killed or injured. We need up-to-date standards of safety to be built into our automobiles, our roadways, our homes, our places of work, our public buildings, our recreation facilities, and any other controllable part of our environment.

It should be the moral and legal responsibility of manufacturers and builders to assure that their products are safe before they go on the market. This concept should include all imported products and should be followed whether we are talking about automobiles, dishes, T.V. sets, chemicals, toys, houses, or trampoline centers.

It should be the responsibility of government to open for traffic only those roadways which come up to safety standards. Many of the streets and roadways in the crowded areas apparently are put together without considering the human at all. The driver is expected to see around blind corners or to squeeze his car suddenly into half its width to accommodate an oncoming car. All kinds of green and red flashing signs advertising theaters, soap, beer, and what have you, compete for attention with the less prominent traffic signals. Pedestrians are now confronted with green traffic signals combined with "don't walk" signs and red signals combined with "walk" signs. These contradictory signals may not be too difficult for stable, sober, attentive adults, but consider the problems of the aged, the intoxicated or those taking certain medicines. A confusing signal can act as the culminating event leading to an accident.

Places of employment are another case in point. It is much less expensive to build safety into a plant, a process, or a machine while it is in the planning stages. By and large, there is little built-in occupational safety, particularly where exposure to dust, chemicals, noise and the like is a problem. Usually, these errors are tracked down only after someone is hurt and the controls which should have been built in must now be added at a much greater expense.

Another area of safety wherein we are far behind in our thinking concerns the responsibility of drivers. The burden of proof should always be on the driver to prove, at any time, that he is a safe driver. We give lip service to the concept of driving being a privilege. Actually, we look upon it as something akin to our constitutional right of free speech. If this is not so, why is there any question about a driver being compelled to take a chemical test for alcohol when the occasion demands? A licensed driver should have just two choices—either he has a test or he loses his license.

Our homes may be castles, but they are often booby traps for accidents. Here is just one example. Poisonings are one of the most serious accident problems for children under five. Homes are particularly well designed to give the crawler and the toddler easy access to hazardous medicines

and other chemicals. What handier place than under the sink for household cleaners and pesticides! What better place for medicine than in a cabinet where a child can climb up on a convenient toilet to reach it! A locked cabinet for hazardous materials should be as standard an item in a home for young children as a high chair or a lock on the front door.

#### Conclusion

Accidents are symptoms of failure on the part of someone or something to function properly. For the most part, accidents are a wasteful and unnecessary by-product of human activity, telling us that we are sloppy and inefficient.

We are in dire need of two things: intelligent, long-term planning for safety, and a widespread sense of moral and social responsibility for the safety of everyone. This planning and responsibility should transcend short-sighted economic interests, which may be "penny wise" but are "millions of dollars" foolish when it comes to the real long-term economic and health interests of us all.

### The Accident Problem In California

This is the fourth in a series relating to the accident problem in California. Death statistics are based on data for 1959. Estimates of persons injured and related figures are based on the California Health Survey.

#### Motor Vehicle Accidents

Throughout the country about 38,000 persons are killed each year in motor vehicle accidents. In 1959 California experienced 3,769 such deaths resulting in a death rate of 24.7 per 100,000 population.

About 18 percent of such deaths were among young men 15 to 24 years old.

About two and a half times as many males as females are in motor vehicle accidents. For ages 20-24, 4.7 times as many men as women die from this cause.

Recent California Health Survey estimates for July 1957 through June 1958 show that 527,000 persons are injured annually in California in motor vehicle accidents.

The highest injury rates (79.3 per 1,000) were for ages 15-24. About 24 percent of all motor vehicle injuries occur to this age group.

### Grants for Wide-Range Research In TB and Respiratory Diseases

The California Research and Medical Education Fund of the Tuberculosis and Health Association of California is inviting applications for research grants. The program, in existence for three years, was broadened last year to include support of investigations into social and psychological factors relating to the prevention and control of tuberculosis and other respiratory diseases. Projects may now be submitted in epidemiologic, social, clinical, laboratory, and related fields of investigation having to do with tuberculosis and other respiratory diseases. Closing date for applications is January 15, 1962.

Chairman of the fund's administrative committee is Homer Peabody, M.D., of San Diego; chairman of the research subcommittee is Henrik L. Blum, M.D., Contra Costa County Health Officer.

For application forms and further information write the Tuberculosis and Health Association of California, 130 Hayes Street, San Francisco 2, California, or telephone HE 1-8771.

The money for the fund comes from the sale of Christmas Seals by local affiliates of the Tuberculosis and Health Association of California.

## Recommendations for Use of Live Polio Virus Vaccine

With the licensing by the Public Health Service of Type I vaccine against paralytic poliomyelitis (on August 17, 1961), oral polio vaccine will become available for use by health departments in controlling or aborting epidemics of Type I polio. It is recommended that Type I oral vaccine be used only in Type I specific pre-epidemics or epidemic situations. It is also recommended that Type I oral vaccine not be used for mass vaccination in the absence of an indicated or actual epidemic.

These recommendations were made by the Executive Committee of the Association of State and Territorial Health Officers and are seconded by the California State Department of Public Health.

Because Type I oral vaccine cannot immunize against Type II or Type III poliomyelitis, its use is not recommended as a substitute for the trivalent killed vaccine (Salk type). This recommendation applies to persons of all ages being vaccinated.

These recommendations are particularly pertinent in view of evidence that a marked shift has occurred in the ratio of polio viruses of the three types in verified cases of paralytic poliomyelitis in the United States.

In 1959, almost 90 percent of the cases were Type I and 10 percent were Type III; in 1960 approximately 75 percent were Type I and 25 percent were Type III. For the first six months of 1961, provisional data indicate that the distribution is roughly 50 percent Type I and 50 percent Type III. Type II has rarely been encountered during the past two and one-half years.

In making its recommendations, the Executive Committee has taken careful note of the historical setting in which oral poliomyelitis vaccine has been introduced within the last two years in contrast to the use of killed poliomyelitis vaccine since 1954. Compared to the average of the last three pre-vaccination years, polio incidence in the United States was about 90 percent less in 1960. Direct observations on the persistence of immunity and the persistence of antibody by killed virus vaccine for the past six years do not indicate that immunity has waned. Comparable observations on large segments of the population are not available for the oral polio vaccine because to date its use has been

only experimental in the United States.

The Committee also made recommendations for the use of oral polio vaccine when all three types become available. (The Public Health Service has announced that Type II is now available and Type III will probably be licensed early in 1962.)

1. The major public health indication for the use of the three types of oral polio vaccine should continue to be for the control of type specific, indicated or actual epidemics.
2. Either the oral or the killed polio vaccines may be used for immunization of infants. The choice is left to the individual physician or the health officer.
3. Either the oral or killed polio vaccines must be used to immunize groups with a low percentage of vaccinated individuals.

Unquestionably, oral vaccine is easier to administer than killed vaccine. However, a question exists whether oral or killed vaccine is more acceptable to people in various population groups, especially those in the lower socio-economic levels. There is little evidence that the mass use of oral vaccine in communities will reach a significant proportion of those persons who did not take the killed polio vaccine when it was offered them. Therefore, we do not expect that a switch from killed to oral vaccine will appreciably reduce either paralytic cases or deaths in communities with an already high percentage of persons immunized to paralytic polio.

The expenditures of public funds and the use of personnel by health departments primarily to re-vaccinate with oral vaccine those already vaccinated with killed vaccine cannot be justified solely on a public health basis. The primary aim should be to concentrate efforts among population groups with a low proportion of persons vaccinated against paralytic polio.

## CALENDAR

1961

**Nov. 13-17**—American Public Health Association Annual Meeting, Detroit

1962

**Feb. 16**—Northern California Public Health Association Meeting, Richmond

**March 22-24**—American Orthopsychiatric Association Meeting, Los Angeles

## Public Health Positions

### Monterey County

**Public Health Nurse:** Salary range \$401-\$496. First increase after six months. Requires California PHN certificate. Vacation and sick leave 15 days each, accumulated annually. State Retirement system. Car allowance 10 cents a mile. Contact M. W. Husband, M.D., Health Officer, Monterey County Health Department, 154 West Alisal Street, Salinas, California.

### Orange County

**Public Health Nurses:** Salary range, \$464-\$575. Positions require California R.N. and P.H.N. certificates and ability to obtain California driver's license. Benefits include three weeks paid vacation, ten holidays, liberal sick leave and free medical insurance. For further information contact: Orange County Personnel Department, 801-C North Broadway, Santa Ana, California.

### San Bernardino County

**Communicable Disease Control Officer:** Salary range, \$940-\$1170. Valid California licensure and a minimum of two years experience required. Completion of one year graduate study in public health may be substituted for the two years experience.

**Medical Examiner:** Salary range, \$940-\$1170. Valid California licensure and a minimum of two years experience required. Completion of one year graduate study in public health may be substituted for the two years experience.

**Supervising Public Health Nurse:** Salary range, \$489-\$608. Effective January 1, 1962, \$516-\$641. Requirements: graduation from school of public health nursing, some formal training in theory and practice of supervision and two years experience as public health nurse.

**Medical Social Work Consultant:** Salary range, \$545-\$608. (Effective January 1, 1962, \$575-\$641). Requirements: completion of two years postgraduate social work course and either one year experience in hospital, clinic, or health department or two years of medical or psychiatric social work experience.

**Public Health Analyst:** Salary range, \$464-\$575. (Effective January 1, 1962, \$489-\$608). Requires education equivalent to graduation from college with at least six units in statistics and research methods and one year of technical or research statistical experience. Six or more semester units of graduate work in public health may be substituted for the required experience. Applicants with three or more years of public health statistical experience will be started at \$516. Effective January 1, 1962, this salary will be \$545.

All positions afford excellent working conditions, including paid vacations, sick leave, holidays, health insurance, liberal retirement plan, plus social security.

For further information write: Department of Civil Service and Personnel, Ground Floor, Courthouse, San Bernardino, California.

### San Mateo County

**Sanitarian:** Salary range, \$477-\$598. Requires certificate as registered sanitarian in State of California. Apply to the Civil Service Commission, Court House, Redwood City, California.

## New Member Appointed to Cancer Advisory Council

Governor Edmund G. Brown has announced the appointment of Thomas S. Nelsen, M.D., Assistant Professor of Surgery at Stanford University School of Medicine, to the State Cancer Advisory Council. Dr. Nelsen has a special interest in cancer surgery. He replaces Henry Kaplan, M.D., also of the Stanford Medical School faculty, who has recently resigned from the Council.

Dr. Nelsen is a native of Tacoma, Washington. He received his bachelor of science and medical degrees at the University of Washington and has been active in teaching and research at the University of Chicago and Illinois Central Hospital. In addition to his current responsibilities at Stanford School of Medicine, he is a consultant to the Palo Alto Veterans Administration Hospital, and is conducting research under a grant from the National Institutes of Health.

The Cancer Advisory Council to the California State Department of Public Health, authorized by the State Legislature in 1959, came into existence late that year. It works closely with the Department to help enforce the antiquackery law passed in 1959 to strengthen the Department's regulatory and control functions in regard to methods used for the diagnosis, treatment, and cure of cancer.

The cancer antiquackery program within the department is known as the Cancer Diagnosis and Therapy Evaluation Unit. Head of this unit is Kenneth F. Ernst, M.D., and assisting him is J. R. Jackson, Field Representative.

The cancer law empowers the Department to require anyone offering cancer treatment to submit samples of the materials they use for testing and evaluation. The Advisory Council recommends suitable investigative and testing procedures to determine the value of the treatment. If misrepresentation or lack of value is found, the Department may ban the treatment.

Cancer quacks using worthless or harmful methods for "diagnosing" or "curing" cancer not only defraud Californians out of millions of dollars each year, but the delay in obtaining diagnosis and treatment by qualified physicians may cost patients their lives.

### Procedure Followed in Antiquackery Control

Questionable methods of diagnosing and treating cancer come to the attention of the Department in a variety of ways. A patient or member of his family may complain to his local better business bureau, medical society, or branch of the American Cancer Society; or someone may report directly to a member of the Advisory Council or the Department staff. The Department then investigates the complaint to determine whether there is ample evidence to justify a hearing. Months of staff time may be involved at this stage of the investigation.

When the Department is satisfied that the reported method is in fact questionable, the individual or individuals involved are subpoenaed to appear at a public investigatory hearing conducted by the State Director of Public Health. The State Attorney General's office and the Advisory Council are also represented at this hearing. At this time, the respondent who may be represented by counsel, is placed under oath and required to demonstrate and/or explain the methods he uses and to answer questions about them. Any materials used, such as chemicals, electronic devices or machines, are made available to the Department for evaluation and testing. After appropriate testing, which may include both laboratory and clinical evaluation as indicated, the Director may order a formal hearing.

At the formal hearing, before a hearing officer from the Attorney General's office, the Department presents evidence that the method in question is worthless or harmful and the respondent is given opportunity for rebuttal. Findings are then submitted to the Advisory Council, which in turn makes a written finding of fact based on the evidence. The Director may then drop the case for lack of evidence, or issue a cease and desist order.

If the cease and desist order should be violated, the Department may seek a Superior court injunction against the violator. Any person against whom an injunction has been issued, (Section 1712, Chapter 7, Division 2 of the Health and Safety Code of California) "may not undertake to use in the diagnosis, treatment, or cure of cancer any new, experimental, untested, or secret drug, medicine, compound, or device without

first submitting it to the Department for investigation and testing."

Since the Advisory Council has been organized, the Department has held three preliminary hearings, two involving use of unproven chemicals, and one involving a device. Further action will be taken on one of these cases after completion of court proceedings.

### Members of Advisory Council

The Advisory Council includes 15 scientists and laymen who are especially interested in the treatment of cancer and in educating of the public about the disease. Malcolm H. Merrill, State Director of Public Health, is an ex-officio member of the Council.

In addition to Dr. Nelsen, members of the Council include:

JOHN W. CLINE, M.D., Assistant Clinical Professor of Surgery at Stanford University School of Medicine, president of the American Cancer Society and chairman of the Council.

SOL R. BAKER, M.D., Assistant Clinical Professor of Radiology at the University of California School of Medicine at Los Angeles

MRS. ROBERT L. BROWN, Encino, chairman of the public education committee, Los Angeles Branch of the American Cancer Society and member of the education committee of the American Cancer Society, California Division

J. HENRY GARLAND, M.D., Clinical Professor of Radiology at the University of California School of Medicine, San Francisco

RICHARD HABER, insurance and hospital television consultant, Berkeley

RAY D. OWEN, Ph.D., Professor and Acting Chairman of the Division of Biological Sciences at the California Institute of Technology

ORLYN B. PRATT, M.D., Head of the Department of Pathology at Loma Linda University School of Medicine

JOSEPH F. ROSS, M.D., Professor of Medicine, Professor of Biophysics and Nuclear Medicine, Director of Laboratory of Nuclear Medicine and Radiation Biology, and chairman of Biophysics and Nuclear Medicine at the University of California School of Medicine at Los Angeles

SOL SILVERMAN, D.D.S., dental surgeon, and Chairman of the Division of Oral Biology of the University of California School of Dentistry, San Francisco

MAURICE H. SIMMERS, D.O., Professor of Pathology and Surgery and Coordinator of Cancer Training at the College of Osteopathic Physicians and Surgeons, Los Angeles

JESSE L. STEINFELD, M.D., Assistant Professor of Medicine, Head of Cancer Chemotherapy Program, Director of Clinical Cancer Traineeship Program, and Director of the Isotope Unit of the University of Southern California School of Medicine, Los Angeles

LOUIS TABAC, president of the City of Hope Medical Center, Los Angeles

DAVID A. WOOD, M.D., Director of the Cancer Research Institute and Professor of Pathology at the University of California School of Medicine, San Francisco



## \$21,636,408 Allocated For Hospital Projects

State and federal matching funds totaling \$21,636,408 were allocated for the construction of 22 California hospitals, public health centers and related health facilities at the October meeting in Los Angeles of the State Hospital advisory Council.

State-federal funds represent two-thirds of project costs. Applicants will provide the remaining one-third of the costs.

The funds were allocated on a basis of priority need as follows:

**General Hospitals:** *Mary's Help Hospital*, Daly City, \$3,767,250; *Siskiyou County Hospital*, Yreka, \$500,980; *John Muir Memorial Hospital*, Walnut Creek, \$2,482,174; and *Alexian Brothers Hospital*, \$2,989,134; *Doctors General Hospital*, \$569,501, and *Good Samaritan Hospital of the Santa Clara Valley*, \$3,203,368, San Jose.

**Psychiatric Hospitals:** *Good Samaritan Hospital of the Santa Clara Valley*, San Jose, \$302,088, and *Hawthorne Community Hospital*, Hawthorne, \$417,854.

**Health Centers:** *Los Angeles County Health Department*, Azusa dis-

trict, \$177,816; *Contra Costa County Health Department*, Martinez, \$105,428; *Placer County Health Department*, Auburn, \$193,886, and *San Jose City Health Department*, San Jose, \$545,298.

**Nursing Homes:** *John C. Fremont Hospital*, Mariposa, \$85,902; *El Centro Community Hospital*, El Centro, \$273,400; *Hawthorne Community Hospital*, Hawthorne, \$457,376; *Presbyterian Intercommunity Hospital*, Whittier, \$516,960; *St. John's Hospital*, Oxnard, \$114,810, and *Mary Health of the Sick Home*, Newberry Park, \$320,286.

**Chronic Disease Hospitals:** *Rancho Los Amigos Hospital*, Downey, \$1,994,514.

**Diagnostic and Treatment Centers:** *Sacramento County Hospital*, Sacramento, \$1,041,690, and *Mt. Zion Hospital*, San Francisco, \$322,568.

**Rehabilitation:** *Glendale Sanatorium and Hospital*, Glendale, \$674,624.

## REPORTED CASES OF SELECTED NOTIFIABLE DISEASES CALIFORNIA, MONTH OF SEPTEMBER, 1961

Disease	Cases reported this month			Total cases reported to date		
	1961	1960	1959	1961	1960	1959
<b>Series A: By Place of Report</b>						
Amebiasis	52	35	64	420	358	487
Coccidioidomycosis	22	14	21	132	172	194
Measles	234	204	307	37,150	21,191	39,257
Meningococcal infections	10	14	13	166	157	159
Mumps	389	792	531	19,973	19,423	9,940
Pertussis	154	209	283	1,536	1,467	1,983
Rheumatic fever	10	5	13	88	114	113
Salmonellosis	107	101	112	1,053	947	874
Shigellosis	208	159	360	1,608	1,516	1,507
Streptococcal infections, respiratory	556	1,475	1,525	11,893	23,344	16,739
Trachoma	7	3	2	18	91	23
<b>Series B: By Place of Residence</b>						
Chancroid	5	10	10	80	93	57
Conjunctivitis, acute newborn	—	—	1	9	12	5
Gonococcal infections	1,916	1,469	1,740	17,132	14,004	12,798
Granuloma inguinale	1	—	—	4	10	1
Lymphogranuloma venereum	4	—	—	8	24	15
Syphilis, total	579	530	598	5,624	5,896	5,206
Primary and secondary	113	110	99	1,120	1,166	802
<b>Series C: By Place of Contraction</b>						
Botulism	—	—	—	—	—	2
Bruceellosis	2	3	1	17	16	10
Diarrhea of the newborn	—	—	14	31	6	54
Diphtheria	—	—	1	2	—	5
Encephalitis	18	32	36	330	419	303
Food poisoning (excluding botulism)	609	161	268	2,122	1,254	1,268
Hepatitis, infectious	439	422	246	4,816	3,412	1,936
Hepatitis, serum	15	16	5	166	97	66
Leprosy	1	—	3	9	7	14
Leptospirosis	1	—	1	5	1	3
Malaria	—	3	3	7	11	23
Meningitis, viral or aseptic	122	103	196	578	539	668
Plague	—	—	—	—	—	2
Poliomyelitis, total	15	72	97	76	354	323
Paralytic	14	62	85	64	309	273
Nonparalytic	1	10	12	12	45	50
Psittacosis	1	—	1	9	11	14
Q fever	—	1	6	26	30	53
Rabies, animal	16	10	12	171	97	100
Rabies, human	—	—	—	1	—	1
Relapsing fever (tick borne)	5	1	3	5	6	3
Rocky mountain spotted fever	1	—	1	1	2	3
Tetanus	4	3	2	22	26	32
Trichinosis	2	1	1	12	3	5
Tularemia	—	1	—	4	3	4
Typhoid fever	9	10	7	49	42	58
Typhus fever (endemic)	—	—	—	3	—	3
Other *	—	—	—	—	—	—
Tuberculosis †	—	—	—	3,507	3,929	3,900

\* This space will be used for any of the following rare diseases if reported: Anthrax, Cholera, Dengue, Relapsing Fever (louse borne), Smallpox, Typhus Fever (epidemic), Yellow Fever.

† Tuberculosis cases are corrected to exclude out of State residents and changes in diagnosis; monthly figures are not published.

## Research Grants Awarded

Two California hospitals have received grants from the Public Health Service to help build and equip additional research facilities. They are Pacific State Hospital in Pomona—\$512,500; and Presbyterian Hospital and Medical Center in San Francisco—\$274,200.

Forty-eight grants totalling \$14,575,628 have been awarded throughout the nation initiating the sixth phase of a \$180 million program established in 1956 and extended by the 85th Congress in 1958. Designed to expand and improve the nation's facilities for medical research, the health research facilities construction program is administered by the Division of Research Grants of the National Institutes of Health. Grants are made to both public and private nonprofit hospitals, medical and dental schools, schools of public health and other research institutions, and are awarded on a matching basis.

"The most widespread and expensive type of quackery in the United States today is in the promotion of vitamin products, special dietary foods, and food supplements. . . . Food quackery today can only be compared to the patent medicine craze which reached its height in the last century."—George P. Larrick, Commissioner of Food and Drugs, U. S. Department of Health, Education, and Welfare.

## Recent Additions to Film Library

The following new 16-mm. films may be scheduled for use by California borrowers. Requests should be sent to the Film Library, Bureau of Health Education, California State Department of Public Health, 2151 Berkeley Way, Berkeley 4, California.

### **Dental Assistant, The—A Career of Service,** 13½ minutes, color, 1961

A career recruitment film for use in guidance counselling to interest high school graduates in a career as a dental assistant. Film shows the career opportunities in this rapidly growing field, highlights the chairside duties of the assistant, and points out the training facilities now available at schools and colleges. For high school and adult groups interested in promotion of health careers. U. S. Public Health Service.

### **Diabetics Unknown,** 22½ minutes, 1961

A film presented in documentary style, portraying diabetics who tell how they found out they had diabetes, what the disease is, and what they are doing about it. Characters range from the very old to a girl of 13, who first found out she had diabetes when she was 11. However, emphasis is on the "over-fat, over forty female—with family tendency toward the disease."

Useful for introducing the subject of screening for early detection of diabetes, and to provide up to date information on the disease. Useful also in training public health workers and social workers for high school and adult groups. (A 6½ minute discussion by a panel of experts may be omitted from a film showing, or may be used for orientation of a live panel presentation following the showing of the main portion of the film.) Public Affairs Committee, Inc.

A pamphlet has been produced to accompany the film and may be purchased from the Public Affairs Committee, Inc., 22 E.

38th Street, New York 16, New York, at 25¢ a copy; discounts on quantities.

### **Hail the Hearty,** color, 28 minutes, 1957

The film contrasts from an historical perspective advances in the science of nutrition in providing resources and knowledge of an adequate diet, and in methods of safeguarding production of our food supply. Special attention is given to the pioneer work of Gail Borden to assure a safer and more nutritious milk supply. Recommended for any group interested in nutrition education. For high school and adults. The Borden Company.

### **Life Cycle of the Fly,** 13 minutes, 1961

Made at the Pasteur Institute of Paris, this film shows the life cycle of the fly in remarkable photography, including unique X-ray sequences. Final metamorphosis and emergence of the adult fly complete the illustrated cycle. Although parasites (wasps) on pupae are described as ants, and the sequence showing fly habitat near water may be misleading, brief statements prior to showing of film may clarify these minor inaccuracies in content. Film should be especially useful for instruction of vector control personnel, and, with suitable discussion for community fly control public education programs. For high school and adults. McGraw-Hill Text Films.

### **Physical Diagnosis—Communicable Diseases,** 30 minutes, color, 1961

A teaching film designed to provide a clinical picture, by use of actual patient demonstration, of some communicable and infectious diseases. Content covers roseola infantum, german measles, measles, herpes simplex, herpes zoster, mycotic pharyngitis, mumps, scarlet fever, lymph node tuberculous adenitis, staphylococcus dermatitis, pertussis, poliomyelitis, encephalitis, bacterial meningitis, and mycotic involvement of the skin. Note: The number of diseases covered and rapidity of narration will require several showings with added discussion. Restricted to use with professional groups, physicians, nurses and public health personnel. Wayne State University.

## Personals

**Henrick Blum, M.D.,** Contra Costa County Health Officer, was presented with an inscribed medallion for "outstanding meritorious efforts in the control of Tuberculosis" during the ninth annual Western Tuberculosis Conference. He had strongly supported the California Tuberculin Testing Program, has conducted a study of reactivated TB cases, and recently completed six years on the board of directors of the California Tuberculosis and Health Association.

**Milton P. Duffy,** for 47 years Chief of the Bureau of Food and Drug Inspections, SDPH, presented a paper, "What We Can Do To Fight Quackery", at the National Congress on Medical Quackery in Washington, D. C. last month. The Congress was sponsored by the American Medical Association and the United States Food and Drug Administration.

Some British cigarette smokers habitually put out an unfinished cigarette, save it, and relight it later. In a study of smokers, three British physicians found about twice as many cases of lung tumors among the re-lighters as among one-time smokers of a pack to one and one-half packs of cigarettes daily. They conclude that if relighting is a factor in lung cancer, it might go part way to explain the much greater incidence of the disease in Britain than in the United States where cigarettes are cheaper. News item, pg. 7, *Today's Health*, October 1961.

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